



Submitting a Medicare Part B Crossover Claim

This informational flier has been created to assist MassHealth providers who bill paper Medicare Part B crossover claims to MassHealth. The first page contains a facsimile of a Medicare explanation of Medicare benefits (EOMB). The second page shows a copy of a HCFA-1500 form, along with fields that are required when submitting a paper claim to MassHealth after Medicare.

What is a Medicare/MassHealth Crossover Claim?

If Medicare has made a payment or applied monies to the coinsurance or deductible for a MassHealth member, then the claim becomes a MassHealth "crossover" claim. The Medicare Part B carrier may transmit these claims electronically to MassHealth, or the provider may manually submit a HCFA-1500 form with a Medicare EOMB. Paper claims are accepted and processed; however, MassHealth strongly urges providers to have their claims cross from Medicare to MassHealth electronically. Providers should submit paper only as a last resort, or if they are submitting a crossover adjustment. Once the claim is received from either Medicare or the provider, there is a 40-60 day processing time before your claim appears on a MassHealth remittance advice (RA). Submitting a paper "tracer" claim will **not** expedite payment. Please reconcile your RAs to ensure that your claims have been processed.

Part 1. The Explanation of Medicare Benefits

The EOMB facsimile below contains highlighted areas with specific billing information. Please refer to the reverse side of this page for details.

Medicare Part B Carrier Company										Medicare Remittance Notice			
1. Provider #: X22222				07/27/00		G.E. Warren Health Services							
Check/EFT #: 123456789						Page #: 2 of 3							
2.	PERF	PROV	SERV DATE	POS	NBS	PRNC	MOBS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME WASHINGTON, GEORGE													
HIC 123456789A				ACNT 4432708		ICN 0100159008780				ASG Y MOA MA01 MA18			
3. W01000	0501	050100	31	4	90801			150.00	138.58	0.00	27.72	CO-B6	11.41
PT RESP	27.72												110.87
CLAIM TOTALS								150.00	138.58	0.00	27.72	11.41	110.87 NET
NAME STEWART, MARTHA													
HIC 978543212A				ACNT 5217088		ICN 0200334477890				ASG Y MOA 4. MA07			
X23707	0701	070100	31	1	98285			310.00	152.48	0.00	30.50	CO-42	42.01
PT RESP	30.50												121.88
CLAIM TOTALS								310.00	152.48	0.00	30.50	42.01	121.88 NET
NAME MAYER, OSCAR													
HIC 428375584A				ACNT 8255544		ICN 078554477890				ASG Y MOA			
D42807	0401	040100	31	1	84443			25.00	0.00	0.00	0.00	PR-38	0.00
PT RESP	30.50												0.00
CLAIM TOTALS								25.00	0.00	0.00	0.00	0.00	0.00 NET
NAME PRINCIPAL, VICTORIA													
HIC 1345789555A				ACNT 2477053		ICN 010055667888981				ASG Y MOA			
H47070	0501	050100	31	1	71010			125.00	0.00	0.00	0.00	0.00	125.00
PT RESP	125.00												125.00
CLAIM TOTALS								125.00	0.00	0.00	0.00	0.00	125.00 NET

7. RID # 5543372304 George Washington

The items below correspond to the highlighted sections on the front side of this page.

1. **Medicare Pay-to-Provider Number.** Your unique Medicare pay-to provider number **must** be on your MassHealth provider file in order for your claims to process, either electronically or on paper. The Medicare pay-to-provider number must be preprinted on the top of the EOMB form and should not be cut off, crossed out, or written over with a different Medicare provider number. If your Medicare provider number is not on the MassHealth provider file, the claims will never appear on a MassHealth RA. To update your Medicare/MassHealth provider file, please contact MassHealth Provider Enrollment and Credentialing using the contact information at the bottom of this page.
2. **Format (Perf Prov, Serv Date, etc.).** For claims submitted on paper, MassHealth currently accepts original EOMBs as well as electronically downloaded EOMBs. Electronic EOMBs must resemble the format of a paper EOMB. Unacceptable EOMBs will be returned to the provider with a letter.
3. **Servicing Medicare Provider Number.** All Medicare provider numbers must have a corresponding MassHealth provider number. To update your MassHealth provider file, please contact MassHealth Provider Enrollment and Credentialing.
4. **MA Codes.** These are informative codes used by Medicare. Medicare will inform the provider if the claim has “crossed over” to MassHealth by using “MA-07.” Before submitting a paper claim, please review your EOMBs for these “MA” codes. If Medicare has indicated that your claim has crossed over electronically, your claim will appear on a MassHealth remittance advice between 40-60 days from the date of the EOMB.
5. **Medicare Denied Claims.** If Medicare denies a claim, the claim will appear on your MassHealth remittance advice denied for error 036, “Medicare denied original claim.” Please refer to your MassHealth provider manual for information about billing claims that were denied by Medicare. Also, if Medicare has paid your claim 100%, then MassHealth has zero liability. These claims will deny on a MassHealth remittance advice for error 035, “Medicare paid 100% of claim.” Do not resubmit these claims to MassHealth.
6. Same as above.
7. **Member RID.** Include the member’s 10-digit MassHealth ID on the EOMB, and always circle the patient information that corresponds to the HCFA-1500. Do **not** use a highlighting marker.

If you require billing assistance or need to update your MassHealth provider file, contact:

MassHealth Customer Service
 Provider Enrollment and Credentialing
 P.O. Box 9118
 Hingham, MA 02043
 1-800-841-2900
providersupport@mahealth.net

Part 2. The HCFA-1500 Form

While HCFA-1500 forms are generally considered universal medical claim forms, MassHealth will accept a HCFA-1500 form **only** as part of a Medicare/MassHealth crossover claim. This means that in order to be processed, a HCFA-1500 form **must** have an EOMB attached to it. HCFA-1500 forms submitted with no attachments or with a third-party liability (TPL) attachment from another insurance company will be returned to the provider.

A paper HCFA-1500 form should be submitted to MassHealth exactly the way you submitted it to Medicare, with minor additions. The form below contains highlighted areas with specific billing information pertinent to MassHealth. Please refer to the reverse side of this page for details.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0038

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (Active or ID) PECA (BLK LUNG) OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT RELATIONSHIP TO INSURED Spouse Child Other

6. PATIENT STATUS Single Married Other

7. INSURED'S ADDRESS (No., Street)

8. CITY STATE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? CURRENT OR PREVIOUS? b. AUTO ACCIDENT? c. OTHER ACCIDENT? d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR PECA NUMBER

12. PATIENT'S DATE OF BIRTH MM DD YY SEX M F

13. EMPLOYER'S NAME OR SCHOOL NAME

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 and 10.

16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

17. SIGNED DATE

18. DATE OF CURRENT ILLNESS (First syndrome) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

19. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

20. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

22. OUTSIDE LAB? YES NO \$ CHARGES

23. MEDICAID RESUBMISSION CODE ORIGINAL REP. NO.

24. PRIOR AUTHORIZATION NUMBER

25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

26. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) OPT/NCPOS MODIFIER

27. DIAGNOSIS CODE

28. CHARGES

29. DAYS OF SERVICE

30. PRIORITY

31. EMB

32. OOB

33. RESERVED FOR LOCAL USE

34. FEDERAL TAX I.D. NUMBER SSN EIN

35. PATIENT'S ACCOUNT NO.

36. ACCEPT ASSIGNMENT? YES NO

37. TOTAL CHARGE \$

38. AMOUNT PAID \$

39. BALANCE DUE \$

40. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made in part thereof.)

41. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

42. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

43. PIN#

44. DRP#

45. DATE

46. PLEASE PRINT OR TYPE

47. FORM HCFA-1500 (12-95) FORM GWCP-1500 FORM RRB-1500

48. REORDER FROM STANDARD REGISTER FORM NO. HC0901B-2

The items below correspond to the numbered areas on the front side of this page.

1. **Fields 9a and 10d.** The member's MassHealth 10-digit RID number is acceptable in either one of these fields. If the RID already exists in field 10d, you may leave it in that location.
2. **Field 1a.** The member's Medicare number should remain in this field.
3. **Field 24C.** This field must be filled with the Medicare type-of-service code. Failure to do this will result in MassHealth error 951, "Invalid Type of Service."
4. **Field 24E.** Please record the member's diagnosis code in this field. Do not use a reference number like 1, 2, or 3.
5. **Multiple Claim Lines.** Each "claim total" on the EOMB is considered a separate claim, and should be submitted with its own matching HCFA-1500 form. Do not combine two or more claim totals on a single HCFA-1500 form.

All of the other information on the HCFA-1500 form should remain the same as when it was submitted to Medicare. If the detail has been denied by Medicare, it must be crossed out on the HCFA-1500 form and EOMB.

Common Errors and Resolutions

The most common crossover billing errors are listed below. These error codes will appear on your MassHealth remittance advice, and can be found in the billing instructions in Subchapter 5 of your MassHealth provider manual.

- 010 "Invalid Recipient ID number."** Make sure that you have indicated the member's MassHealth 10-digit ID number in **one** of the following places:
- written on the EOMB manually;
 - in Field 9a on the HCFA-1500 form; or
 - in Field 10d on the HCFA-1500 form.
- 035 "Medicare Paid 100% of Claim."** There is no further reimbursement for this claim. If Medicare has paid 100% of the claim, MassHealth has zero liability.
- 036 "Medicare Denied Original Claim."** Medicare has denied your claim. Please rebill to Medicare if necessary, and refer to the MassHealth billing instructions for information about claims submission to MassHealth after Medicare has denied the claim.
- 103 "Duplicate Claim."** Your claim has been paid on a previous MassHealth RA. Always reconcile your RAs before billing a "tracer" or duplicate claim.
- 951 "Invalid Type of Service."** Check to see if you included the correct Medicare type of service in Field number 24C. If you submit your claims electronically, they will not deny for error 951.

Completed Crossover Claims should be submitted to:

MassHealth
Attn: Crossovers
P.O. Box 9118
Hingham, MA 02043